MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-C

01445

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or insf. (yrs., or mos., or days) 23 Days

Stay in this community (yrs., or mos., or days) 60 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 91 College Ave
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Rinehart R. Ackenbach

3. (b) Social Security Number None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widowed

B (b) Name of husband or wife Margaret C. Ackenbach

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 1 1861

8. AGE: Years 78 | Months 7 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired. Gen Helper

11. Industry or business Naval Academy

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Walton W. Ackenbach

Address 93 College Ave Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6 1940 (month) (day) (year)

Cemetery or crematory St. Annes

Location Annapolis, Md.

18. Funeral director B.L. Hopping

Address Annapolis, Md.

19. 2 6 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1940, at 6 25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1940, to Feb 2 1940, and that I last saw h im alive on Feb 2 1940.

Immediate cause of death: acute purulent infection naso pharynx and sinuses — DURATION: Jan 20 1940

Due to

Due to Carcinonama antrum — Unknown

Other conditions + frontal sinus

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE J. Willis Martin M.D. M. D. or other

Address Annapolis Md Date signed 2/5/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01446

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
U.S.Naval Hospital,Annapolis, Md.

Stay in hospital or inst. (yrs., or mos., or days): 6 months 5 days

Stay in this community (yrs., or mos., or days): 58 years-4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 58 Cathedral Street.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME
William (None) Booze

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Claudell Booze

6(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 10 16 1881

8. AGE: Years	Months	Days	If less than one day
58	3	27	____hrs. ____min.

9. Birthplace: Annapolis, A.A., Maryland
(Town, county, and stete)

10. Usual occupation: Officer's Cook, U.S.N.

11. Industry or business: Retired, U.S.Navy.

FATHER
12. Name: William Booze
13. Birthplace: Baltimore, Maryland.

MOTHER
14. Maiden name: Elizabeth Hebron
15. Birthplace: Laurel, Maryland.

18. Informant: R.M.LHAMON,Captain,(M.C.).,U.S.Navy.
Address: U.S.Naval Hospital,Annapolis,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-16-40 (month) (day) (year)

Cemetery or crematory: Naval Academy Cemetery

Location: U.S.Naval Academy,Annapolis,Md.

18. Funeral director: J. B. Johnson

Address: 34 Lafayette Ave.,Annapolis,Md.

19. 2 16 19 40 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13,1940 19 10:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 38 to Feb.13, 19 40, and that I last saw him alive on 13 February 1940. 19

Immediate cause of death	Heart failure	DURATION
Due to	Myocarditis, Chronic	3 years
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy (Congestive heart failure Dilation right heart)

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert L. Ware,Lieut.(M.C.).,USN,
U.S.Naval Hospital,Annapolis,Md. M.D. or other

Address Date signed 2-13-40.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2 — 11447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport A. A. Co Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 814 Chester Ave Ext.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Mildred Agnes Briand

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Leo Patrick Briand
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 15 - 1883

8. AGE:

Years	Months	Days	If less than one day
56	4	27	hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Robert Brown
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Leo P. Briand
Address: 814 Chester Ave Ext. Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 13th 1940 (month) (day) (year)
Cemetery or crematory: U.S. Naval Cemetery
Location: Annapolis Md.

18. Funeral director: John W. Saylor
Address: Annapolis Md.

19. 2 13 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10th 1940, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31st 1939 to Feb 10th 1940, and that I last saw her alive on Feb 10th 1940

Immediate cause of death		DURATION
Due to	Apoplexy.	11 days.
Due to		
Other conditions	Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J J Russell M.D.
M. D. or other
Address: Eastport Date signed: 2-12-40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

WITHIN CORPORATE LIMITS 01448

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 90 Johnson st
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 96 Johnson st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Benjamin Brown

3. (b) Social Security Number 215-09-1951 Coast.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 25, 1888

8. AGE: Years 51 | Months 7 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace A. A. Co (Chesterfield)
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Brown
13. Birthplace A. A. Co

MOTHER
14. Maiden name Martha Gray
15. Birthplace Md.

16. Informant Charlie Brown
Address Calvert st

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20/40 (month) (day) (year)
Cemetery or crematory Potters field
Location Annapolis
18. Funeral director J. B. Johnson
Address Annapolis
19. 2-20 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 1939 to Feb. 15 1940
and that I last saw him alive on Feb. 15 1940

Immediate cause of death	DURATION
Carcinoma of liver	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lawrence W. Greene M.D.
M. D. or other
Address Annapolis, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

01449

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Annerundel

City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Monument Street

Stay in hospital or inst. (yrs., or mos., or days): no

Stay in this community (yrs., or mos., or days): 69 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Annarundel

City or town: Annapolis Md Ward No. 4
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7 Monument St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Jane Brown

3. (b) Social Security Number: None

4. Sex: Fem

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm Brown

Deceased 6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): Feb 20 1869

8. AGE: Years 69. Months 11 Days 2 95 If less than one day: None hrs. None min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: at Home.

FATHER
12. Name: Petter Jennings
13. Birthplace: Annapolis Maryland

MOTHER
14. Maiden name: Cinderala - unknown
15. Birthplace: Annapolis Maryland

16. Informant: Wm Brown

Address: 7 Monument St

17. St Ann Cemt. (Burial, cremation, or removal. Which?) Date thereof 2. 8. 1940 (month) (day) (year)

Cemetery or crematory: St Ann Cemt.

Location: Annapolis Maryland.

18. Funeral director: E. H. B. Parker.

Address: 47 Washington St

19. 2 7 1941 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5 1940, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1940, to Feb 5 1940, and that I last saw her alive on Feb 5 1940.

Immediate cause of death: Hemiplegia — DURATION 2/1/40

Cerebral hemorrhage C.V.S.R.

Due to: Duration three weeks

Senility

Due to: Arterio sclerosis

Other conditions: Arterial Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: J. Willis Martin M.D. (M. D. or other)

Address: Annapolis Date signed 2/7/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

01450

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harwood P.O.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sadie Thomas Farm
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Sadie Thomas Farm
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: John W. Brown

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug. 18, 1866

8. AGE:

Years	Months	Days	If less than one day
73	5	17	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farm Labor

11. Industry or business: general farming

FATHER
12. Name: John W. Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret W Huntington
15. Birthplace: Maryland

16. Informant: Richard Brown
Address: Harwood P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1940 (month) (day) (year)

Cemetery or crematory: Adams Chapel
Location: Lothian

18. Funeral director: T. A Hardesty & Son
Address: Galesville, Md

19. 2/5 1940 (Date rec'd by registrar) H. E. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febr. 2 1940, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem examination
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Acute myocardial failure	sudden
Due to: Arthritis left hip	
Due to: and spine	10 years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey Deputy medical Examiner
(M. D. or other)
Address: Annapolis Md Date signed 2/3/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01451

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 6 days
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: ODELL BROWN

3. (b) Social Security Number: 214-16-8733 Post ~~Unknown~~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6 (b) Name of husband or wife: ------
6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years	Months	Days	If less than one day
30?	Unknown		------hrs. ------min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/16/40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt.
Address

19. 4/Feb/16 (Date rec'd by registrar) 1940 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13th 1940, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7th 1940, to Feb. 13th 1940, and that I last saw him alive on Feb. 13th 1940.

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to	
Other conditions: Gonorrhea	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------
Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ----- Injured at work? -----

23. SIGNATURE: Clark D. Smith M. D. or other
Address: Crownsville, Md Date signed 2/13/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (932)

01452

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Dorsey Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 30 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Harmans Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no.

3. (a) FULL NAME Tecumseh (Columbus) Burley
3. (b) Social Security Number none

4. Sex male
5. Color or race col
6. (a) Single, married, widowed, or divorced Widowed.
6 (b) Name of husband or wife Ida Johnson Burley
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) aug 1863

8. AGE: Years 76 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Gabriel Burley
13. Birthplace Prince George Co Md
MOTHER 14. Maiden name Martha Harris
15. Birthplace Prince George Co
16. Informant Rosa Chase
Address Dorsey, Md.
17. Burial Date thereof Feb 20 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Mark's Cemetery
Location Anne Arundel Co
18. Funeral director Mrs Hattie R Williams
Address 322 N Schroeder St
19. Feb. 20, 1940 M. R. DeAlba Dep
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1940, at 7 20 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1939, to Feb 17 1940, and that I last saw him alive on Feb 16 1940.
Immediate cause of death Myocardial insufficiency — DURATION 5 mo
Due to General arteriosclerosis — ?
Due to
Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other
Address Elkridge Date signed 2/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

FEB 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 01453 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Round Bay
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Round Bay Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Spanish American & World.

3. (a) FULL NAME Norvell Pearson Chapman

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Annetta V. Chapman
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1st 1879
8. AGE: Years 60 Months 10 Days 24 If less than one day hrs. min.
9. Birthplace Perryman Harford Co Md.
(Town, county, and state)
10. Usual occupation Real Estate
11. Industry or business
FATHER 12. Name Pearson Chapman
13. Birthplace Charles Co Md.
MOTHER 14. Maiden name Edmonia Ward
15. Birthplace Lyells Va
16. Informant Annetta V. Chapman
Address Round Bay A.A.C. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 27 1940 (month) (day) (year)
Cemetery or crematory St Annes
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 2-26 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1940, at 7 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1940, to Feb 25, 1940, and that I last saw him alive on ~~Jan~~ 24 Feb 1940.
Immediate cause of death Uraemic poisoning — DURATION 1 wk.
Due to Chr. Nephritis
Due to Arteriosclerosis & Hypertension
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, Md M. D. or other
Address 31 South Gate Av Date signed 2/26/40

VS A15 (T) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01454

Reg. Diat. No. 2 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: West River

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: West River Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Annie McCaleb Clayton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife: -

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 23, 1867 Feb. 2, 1940

8. AGE:

Years	Months	Days	If less than one day
73		10	hrs. min.

9. Birthplace: West River, A.A. County, Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: William G. Clayton, M.D.

FATHER — 13. Birthplace: West River, A.A.Co. Md.

MOTHER — 14. Maiden name: Gertrude Pindell

MOTHER — 15. Birthplace: A.A. County, Md.

16. Informant: Sister, Miss Hattie Clayton.

Address: West River, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 4th 1940 (month) (day) (year)

Cemetery or crematory: Christ Church Yard

Location: West River A.A.Co. Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 2 2 1940 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1940, to Feb. 2 1940, and that I last saw him alive on Feb. 1 1940.

Immediate cause of death	Myocardial failure	DURATION
Due to	-	
Due to		
Other conditions	Malnutrition	
	Dementia precox	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. M. D. or other

Address: Sotheron, Md. Date signed: Feb. 3, 1940

RECEIVED
MAR 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01455

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 19 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Ridgely Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: FLORENCE COLLINS

3. (b) Social Security Number: Unknown

4. Sex: female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 61 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Collins
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 3/9 40
(month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. 3/9 40 19
(Date rec'd by registrar)

E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 27th 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8th 1937, to Feb. 27 1940, and that I last saw her alive on Feb. 27th 1940.

Immediate cause of death: Pulmonary tuberculosis - right and left upper lobes

DURATION: 1 yr. 9 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ------

Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 2/27/40

RECEIVED
APR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01456

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) Emergency Hospt.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 17 Eastern Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas J. Corner

3. (b) Social Security Number Conn. 214-05-1876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alva W. Corner
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12th 1887

8. AGE:

Years	Months	Days	If less than one day
52	5	17	hrs. min.

9. Birthplace St Margarets A.A.C. Md.
(Town, county, and state)
10. Usual occupation Supt. Bath Life Ins. Co.
11. Industry or business Annapolis, Md

FATHER
12. Name Theo. S. Corner
13. Birthplace A.A.C. Md

MOTHER
14. Maiden name Prudence Megick
15. Birthplace A.A.C. Md.

16. Informant Frank C. Corner
Address Eastport A.A.C. Md

17. Burial Date thereof Mar 3rd 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Margarets Cemt.
Location St Margarets A.A.C. Md.
18. Funeral director Todd M. Taylor
Address Annapolis Md.

19. 3-2 1940 J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29th 1940, at 9.09 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1940 to Feb 29 1940, and that I last saw h[illegible] alive on Feb 29 1940.

Immediate cause of death	DURATION
Dilatation of Heart	Sudden
Due to Coronary Thrombosis	" "
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Oliver Purves M. D. or other
Address Annapolis Md Date signed 3/1/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 186a

Reg. Dist. No. 23

CERTIFICATE OF DEATH

01457

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Ferndale Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Hollins Ferry Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 7yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hollins Ferry Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? 60 years

3 (a) **FULL NAME** Samuel Repton Cox, Sr.

3 (b) If veteran, name war: No | 3 (c) Social Security No.: No

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Carrie Francis Cox deceased

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 30 - 1857

8. AGE: Years 87 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace Staffordshire Eng.
(Town, county, and state)

10. Usual occupation Retired Glass Blower

11. Industry or business

FATHER
12. Name William S. Cox
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Samuel R. Cox Jr.
(b) Address 86 Summer ave, Bellevue Pittsburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-40 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director William Cook
(b) Address 1217 St Paul St

19 (a) Feb. 9, 1940 (Date rec'd by Registrar) (b) Arde Alba Dep Registrar

MEDICAL CERTIFICATION

20. Date of death February 9 1940, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to Feb. 9 1940, and that I last saw him alive on Feb. 6 1940.

	Duration
Immediate cause of death: Bronchial Pneumonia	5 days
Due to Cerebral Pneumonia	
Generalized Arteriosclerosis	
Due to Senility	
Other conditions Lacerated Scalp	7 days
Cerebral Concussion	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Feb. 2, 1940
(c) Where did injury occur? Ferndale (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs

23. Signature Earl R. Wilder M.D. M. D. or other
Address Ferndale, Md. Date signed Feb. 9, 1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

FEB 17 1940
BUREAU V. S.

01458

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 das.

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Benedict Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: ANGELINE CRAIG

3. (b) Social Security Number: --------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	black	single

B (b) Name of husband or wife: -------

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 70 ? Months: Unknown Days: It less than one day: ___ hrs. ___ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER
12. Name: Sandy Craig
13. Birthplace: Maryland

MOTHER
14. Maiden name: Tillie (Unknown)
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/12-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt.

Address

19. 2/12 40 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2nd, 1940, at 2:25P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from M. January 31st 1940, to Feb. 2nd 1940 and that I last saw her alive on Feb. 2nd 1940.

Immediate cause of death: Carcinoma of breast — DURATION: ?

Due to

Due to

Other conditions: -------
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------

Of autopsy: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ---- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 2/2/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01459

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 21

Village or City Crownsville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. mos. 5 ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Marion Denmark If U. S. Veteran, specify WAR

(a) Residence: No. 1039 Saratoga St., Baltimore, Maryland

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Black	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of --

6. DATE OF BIRTH (month, day, and year) 8/1/22

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	6	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. --

10. Date deceased last worked at this occupation (month and year) -- 11. Total time (years) spent in this occupation --

12. BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

FATHER

13. NAME Harry Denmark

14. BIRTHPLACE (city or town) unknown (State or country) Maryland

MOTHER

15. MAIDEN NAME Eleanor Hackey

16. BIRTHPLACE (city or town) Frederick (State or country) Maryland

17. INFORMANT Hospital Records. (Address) Crownsville, Maryland

18. BURIAL, CREMATION, OR REMOVAL Frederick, Md. Date 2/4/40, 19

19. UNDERTAKER Elroy Wilson. (Address) 1000 Brantley Rd. Baltimore, Md.

20. FILED 2/27 40, 19 E.T. Joyce Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 26 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1939, to Feb. 26, 1940

I last saw her alive on Feb. 26, 1940; death is said to have occurred on the date stated above, at 6:45a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Epileptiform convulsions due to Juvenile Paresis	unk.

Other Contributory Causes of Importance:

Congenital syphilis

Name of operation none Date of --

What test confirmed diagnosis? -- Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? -- Date of Injury -- 19--

Where did injury occur? -- (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. --

Manner of injury --

Nature of injury --

24. Was disease or injury in any way related to occupation of deceased? --

If so, specify --

(Signed) Gustave A. Paribeau M.D.

(Address) Crownsville, Maryland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED MAR 5 1940 BUREAU V.S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Marion Denmark #132
Baltimore, Md.
Admitted Feb. 21, 1939
Died February 26, 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

01460

Reg. Dist. No. 2-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days) 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Galesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Mrs Susie A. Dubel

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife James E. Dubel

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) V

8. AGE:

Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace Catonsville, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Edward Minnick

13. Birthplace Md

MOTHER 14. Maiden name Mc Nett

15. Birthplace Md.

16. Informant Mrs J. Edward Smith

Address Galesville, Md.

17. Burial Date thereof Feb 17 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Quaker Cemetery

Location Galesville

18. Funeral director T. A. Hardesty & Son

Address Galesville

19. 2/16 1940 J. J. Murphy
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1940, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1940, to Feb 15 1940, and that I last saw h er alive on Feb 15 1940.

	DURATION
Immediate cause of death: Myocardial Insufficiency	1 mo
Due to: Chronic arteriosclerosis	
Due to: Chronic arterial hypertension	
Other conditions: Chronic endocarditis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.
M. D. or other

Address Annapolis Md. Date signed 2/15/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93-d

Reg. Dist. No. 23

CERTIFICATE OF DEATH

01461

1. PLACE OF DEATH:
(a) County: Anne Arundel
(b) City or town: Jessup (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in this community (yrs., mos., or days): 70 yr.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State: Md. (b) County: a a
(c) City or town: Jessup (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Daniel Edwards

3 (b) If veteran, name war: No
3 (c) Social Security No.: None

4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida Edwards
6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.): May 10 1878

8. AGE: Years: 61 Months: 8 Days: 12 If less than one day: hr. min.

9. Birthplace: A. A. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farming

FATHER
12. Name: Nathan Edwards
13. Birthplace: Arundel Co Md

MOTHER
14. Maiden Name: Achsia —
15. Birthplace: Arundel Co. Md

16 (a) Informant: Jorge Edwards
(b) Address: Arundel Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27th /40 (month) (day) (year)
(c) Cemetery or crematory: Jennies Branch
Location: Arundel Co Md

18 (a) Funeral director: Calvin O Wilson
(b) Address: 1000 Brantley Ave

19 (a) Feb. 24 (Date rec'd by registrar) (b) Rose Elba Dep. Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 22 1940, at 4:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1940, to Feb 22 1940, and that I last saw him alive on Feb 22 1940.

Immediate cause of death	Duration
Cardia-Vascular Disease	One yr.
Due to Grippe	5 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Chas L. Ball Jr. M.D. (M. D. or other)
Address: Laurel Md. Date signed 2-22-40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 6 1941
BUREAU U. S.

01468

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town West Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town West Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. West Annapolis Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Otho Burgess Gover

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26th 1861

8. AGE: Years 78 Months 10 Days 29 If less than one day hrs. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George S Grover

13. Birthplace Maryland

MOTHER 14. Maiden name Annie E. Robinson

15. Birthplace Maryland

16. Informant Emmett S Gover

Address 2816 Jefferson St Balto Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 27th 1940 (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship A.A. Co Md

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 2-26th 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 24 1940, at about 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Post Mortem Examination 19

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION sudden

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Claffey Deputy Medical Examiner M. D. or other

Address Annapolis, Md Date signed 2/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-20)

01462

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Skidmore
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Skidmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Alverta Green

3. (b) Social Security Number none

4. Sex Fem
5. Color or race colored
6. (a) Single, married, widowed, or divorced single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 16 1910

8. AGE: Years 24 Months 6 Days 20 If less than one day hrs. min.

9. Birthplace Skidmore (Town, county, and state)
10. Usual occupation house work
11. Industry or business
FATHER 12. Name John Green
13. Birthplace Arnold A. A. Co.
MOTHER 14. Maiden name Bessie Colbert
15. Birthplace Skidmore
16. Informant Bessie Green
Address Skidmore
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7 1940 (month) (day) (year)
Cemetery or crematory Broadneck
Location A. A.
18. Funeral director J. B. Johnson
Address Annapolis
19. 2 7 40 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940, to Feb 5 1940, and that I last saw her alive on Feb 5 1940.

Immediate cause of death Pneumococcic meningitis Type 28.
Due to
Due to
Other conditions Amenorrhea.
(Include pregnancy within 3 months of death)
Major findings:
Of operations Spinal fluid cloudy c̄ pedicle formation.
Of autopsy none.

DURATION 5 days.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, Md M. D. or other
Address 31 South Gate Rd Date signed 2/7/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

01463

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 mo. 15 das.

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Anne Arundel~~

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 913 Arlington Ave., Goveans, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---------

3. (a) FULL NAME: ERNEST GREEN

3. (b) Social Security Number: ~~Unknown~~ 217-03-8748 Ross

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	black	married

6 (b) Name of ~~husband or wife~~ XXXX: Daisy Green

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE:

Years	Months	Days	If less than one day
55	Unknown		hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: -----

FATHER
12. Name: James Green
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Emma Pratt
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 2-21-40 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Cem.

Location: Arbutus, Md.

18. Funeral director: Thomas E. Kelson

Address: 1303 Prestman St. Baltimore

19. Feb. 19 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19th 1940, at 8:55A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4th 1939, to Feb. 19th 1940, and that I last saw him alive on Feb. 19th 1940.

Immediate cause of death: General paralysis of the insane

Due to:

Due to: Lues

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -----

Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 2/19/40

FEB 26 1940
BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01464

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 8 days

Stay in this community (yrs., or mos., or days) 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Troop Landing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Gertrude Helen Green

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1922

8. AGE: Years	Months	Days	If less than one day
17	10	19	hrs. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business In own home

FATHER 12. Name Edward Green

13. Birthplace Annapolis, Md.

MOTHER 14. Maiden name Fannie Meades

15. Birthplace Md.

16. Informant Maggie Meades

Address Troop Landing

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23 1940 (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship

18. Funeral director T. A. Hardesty & Son

Address Galesville, Md.

19. 2-20 (Date rec'd by registrar) 19 40 J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1940, at 7A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1940, to Feb 20 1940, and that I last saw h-er alive on Feb. 20 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to Broncho Pneumonia	4 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

0t operations

0t autopsy Crane

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M. D.
M. D. or other

Address Annapolis Date signed 2/20/40

FEB 27 1940
BUREAU U. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS OF

01465 21

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 29 Shaw St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 4 yrs. 8 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 29 Shaw St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: James W. Green

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	negro	S

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 18. 1935

8. AGE:

Years	Months	Days	If less than one day
4	8	26	hrs. min.

9. Birthplace: Baltimore Md

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Bernard Jacobs

13. Birthplace: Md

MOTHER

14. Maiden name: Arneta Hebrin

15. Birthplace: Md

16. Informant: Cholotte Green

Address: 29 Shaw

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 16/40 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 2/16 19 40 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 13 1940, at 10 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination, and that I last saw h alive on 19

Immediate cause of death	DURATION
Convulsions	sudden
Due to Lobar Pneumonia;	4 days
Due to C.W.G.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no operations

Of autopsy: no autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John McCaffy Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed: 2/15/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-a)

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 01466

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md. Ward No. 1

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 195 Hanover St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emily Ash Griffin

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Thomas E. Griffin

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 17th 1865

8. AGE:

Years	Months	Days	If less than one day
74	2	1	____ hrs. ____ min.

9. Birthplace West River A-A-Co Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Richard Clayton

13. Birthplace West River A.A.Co. Md.

MOTHER 14. Maiden name Helen Ash

15. Birthplace Penn.

16. Informant Thomas C. Griffin

Address 195 Hanover St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 20th 1940 (month) (day) (year)

Cemetery or crematory Naval Cemetery

Location Annapolis Md

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 2-19 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1940, at 2.9. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1940 to Feb 18 1940, and that I last saw her alive on Feb. 18 1940.

Immediate cause of death	DURATION
Myocardial Insufficiency	2/15/40
Due to acute Bronchitis	2/13/40
Due to Chronic Bronchial asthma	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE J. Willis Martin M.D.

M. D. or other

Address Annapolis Md Date signed 2/18/40

RECEIVED
MAR 8 1940
BUREAU V. S.

01467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131 B)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: G. A.

City or town: Tracy's Landing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Tracy's Landing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Henry Gross

3. (b) Social Security Number: None

4. Sex: male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eliza Gross

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years 85 | Months | Days | If less than one day ___ hrs. ___ min.

9. Birthplace: Calvert Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Eliza Smothers
13. Birthplace: A. A.

MOTHER
14. Maiden name: Eliza Gross
15. Birthplace: Calvert Co.

16. Informant: Mary Gross

Address: 14 Fleet St Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Feb. 24 40
(month) (day) (year)

Cemetery or crematory: Carter's Chappel

Location: Friendship

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 2-23 1940
(Date rec'd by registrar)

W. R. Clayton
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21st 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1940, to Feb. 21 1940, and that I last saw him alive on Feb. 18 1940.

Immediate cause of death	DURATION
1 Acute Myocarditis ?	?
2 Chronic Nephritis	?
Due to Influenza	2/16/40
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: F. B. West
M. D. or other

Address: Lothian, Md. Date signed: 2/22/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County aa

City or town Friendship

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County aa

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR Vw

3. (a) FULL NAME Mary M. Hardesty

3. (b) Social Security Number None

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced W

8 (b) Name of husband or wife Perry Hardesty

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1838

8. AGE: Years 81 Months 2 Days 26 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Hubbons

13. Birthplace Md

MOTHER 14. Maiden name Sarah Austin

15. Birthplace Md

16. Informant E. Hardesty

Address Friendship

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22, 1940 (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship, Md.

18. Funeral director Robert J. Wood

Address Friendship, Md.

19. 2-22 1940 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1940, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1939, to 2/20 1940, and that I last saw h— alive on 2/19 1940.

Immediate cause of death Paralysis — DURATION 8 wks

Due to Hypertension — 1

Cerebral hemorrhage.

Due to Duration: Six weeks. [illegible]

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hugh W Ward M. D. or other

Address Ownings Md Date signed 2/21/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-a)

01470

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: a-a-
City or town: St Margrets
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Skidmore
Stay in hospital or inst. (yrs., or mos., or days): Non
Stay in this community (yrs., or mos., or days): No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: a-a-
City or town: St Margrets Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: St Margrets
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant Harris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col-	Single

B (b) Name of husband or wife: None

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb 10, 1940

8. AGE:

Years	Months	Days	If less than one day
[illegible]		6	____ hrs. ____ min.

9. Birthplace: St Margrets (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Milton Harris
13. Birthplace: St Margrets

MOTHER
14. Maiden name: Estella Elizabeth Johnson
15. Birthplace: St Margrets Md.

16. Informant: Walter Johnson
Address: Skidmore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19 1940 (month) (day) (year)
Cemetery or crematory: Broad Neck Grad
Location: St Margrets Md
19. Funeral director: E H B Parker
Address: 47 Washington St

19. 2-19 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 16 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination and that I last saw h[illegible] alive on ____ 19____.

Immediate cause of death	DURATION
Congenital debility	6 days
Due to: Malformation of Head	6 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: Injured at work?

23. SIGNATURE: John M. Cathy Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed 2/18/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01471

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 11 mos. 26 das.
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 309 N. Calhoun Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME
JAMES HENDERSON

3. (b) Social Security Number
~~Unknown~~ 439-12-6589 Poss

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	black	single

6 (b) Name of husband or wife: -------
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1912 June 12th

8. AGE: Years	Months	Days	If less than one day
27	8	2	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General
FATHER
12. Name: Lloyd Henderson, dead
13. Birthplace: Unknown
MOTHER
14. Maiden name: Sarah Downey
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16-40 (month) (day) (year)
Cemetery or crematory: Laurel
Location: Balto. Md
18. Funeral director: Mrs. George H. Holland
Address: 1631 David Hill Ave Balto Md
19. 2/14-40 (Date rec'd by registrar) 19__ E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14th 1940, at 5 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18th, 1937, to Feb. 14th 1940, and that I last saw him alive on Feb. 14th 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work?

23. SIGNATURE: Joseph L. Hinkerods M. D. or other
Address: Crownsville, Md. Date signed: 2/14/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 20 1940
U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

WITHIN CORPORATE LIMITS 01472

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) 2 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 175 Chestnut St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Malvin Henson

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: Col.
6. (a) Single, married, widowed, or divorced: X
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 28, 1939

8. AGE: Years | Months 6 | Days 4 | If less than one day hrs. min.

9. Birthplace Annapolis Md. A.A.Co.
(Town, county, and state)
10. Usual occupation None
11. Industry or business "

FATHER
12. Name Vinson Henson
13. Birthplace St. Margarets Md

MOTHER
14. Maiden name Gladys Jackson
15. Birthplace Mt Calvery Md.

16. Informant Gladys Henson
Address 175 Chestnut

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-40 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location out side Annapolis
18. Funeral director Charles H. Alexander
Address 43.45 Northwest st. Annapolis Md.

19. 2-3rd 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2. 1940, at 4:09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1940, to Feb. 2 1940, and that I last saw h[illegible] alive on Feb. 2, 1940.

Immediate cause of death Bronchi - Pneumonia, primary. No associated disease. [illegible] — DURATION 5 days
Due to Cerebrate Organism not isolated
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D. M. D. or other
Address Annapolis, Md. Date signed 2/7/40

RECEIVED
MAR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-d)

CERTIFICATE OF DEATH

01473

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Station Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days): 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G. Meade, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Joseph G. Hill

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: unk

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 3, 1883

8. AGE:

Years	Months	Days	If less than one day
56	5	18	hrs. min.

9. Birthplace: Ridgeway, Illinois
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: unk.

MOTHER
14. Maiden name: Unknown
15. Birthplace: unk.

16. Informant: Service Record
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 24, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Ridgeway, Illinois

18. Funeral director: Robert Brooks and Son

Address: Baltimore, Maryland

19. February 21 1940 (Date rec'd by registrar) D. P. CARD, Registr., M. C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 1940, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 1940, to February 21 1940, and that I last saw him alive on February 21 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage, Apoplexy	5 hrs
Due to Arteriosclerosis	5 yrs
Due to Myocarditis, chronic	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at (home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: JOHN J. MADIGAN
Lt. Col., Medical Corps, M. D. or other

Address: Ft. Geo G Meade, Md Date signed: Feb 21/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

01474

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or insf. (yrs., or mos., or days) NONE

Stay in this community (yrs., or mos., or days) NONE

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Shadyside Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. None

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Holland - Sex undetermined

3. (b) Social Security Number

4. Sex: not for registry to determine sex.

5. Color or race: col.

6. (a) Single, married, widowed, or divorced: (Nursing)

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 3, 1940

8. AGE: Years: Nursing - No age | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis, Md. (Town, county, and state)

10. Usual occupation: Nursing

11. Industry or business: Nursing

FATHER

12. Name: unknown

13. Birthplace

MOTHER

14. Maiden name: Margaret Louise Holland

15. Birthplace: Md.

16. Informant: Margaret Louise Holland

Address: Shadyside - Md

17. ____ Date thereof ____ (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. ____ 19____

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1940, at 3A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2, 1940, to Feb. 3 1940, and that I last saw h alive Nursing 19____

	DURATION
Immediate cause of death	
Due to Nursing	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Albert L. Andersen M. D. or other

Address Annapolis, Md. Date signed 4/17/40.

Stillb.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

01475

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Rural near Glen Burnie Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co

City or town: Rural near Glen Burnie. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Lynn Corner

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Arthur Charles Hostler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Emily Mary Hostler

6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): July 27, 1867

8. AGE:	Years	Months	Days	If less than one day
	72	7	19	— hrs. — min.

9. Birthplace: London. England.

(Town, county, and state)

10. Usual occupation: Sea Captain. Retired

11. Industry or business: Shipping

FATHER

12. Name: Charles Hostler

13. Birthplace: England.

MOTHER

14. Maiden name: unknown.

15. Birthplace: England.

16. Informant: Arthur Charles Vicary Hostler

Address: Pasadena. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10 - 40 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem - Baltimore

Location: Baltimore Md.

18. Funeral director: Nelson Cook.

Address: 121 St. Paul St. Baltimore, Md.

19. Feb. 8 1940 (Date rec'd by registrar) Dr. L. A. Brent, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8th 1940, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937, to Feb 8 1940, and that I last saw him alive on Feb 7 1940.

	DURATION
Immediate cause of death: Chronic Valvular Disease of the Heart	5 years
Due to: Arteriosclerosis	5 years.
Due to:	
Other conditions: Chronic Interstitial Nephritis	5 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James S. Billingsley M.D. M. D. or other

Address: Glen Burnie. Md. Date signed: Feb. 8 1940.

RECEIVED
MAR 5 1940
BUREAU F. S.

01476

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 month 2 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: ALICE HOWARD

3. (b) Social Security Number: 253-14-3635 ~~Unknown~~

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	black	married

6 (b) Name of husband or wife: Robert Howard

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years: 34 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/27-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address:

19. 2/27/ 1940 (Date rec'd by registrar) E. J. Joyce DC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19th 1940, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17th 1940, to Feb. 19th 1940, and that I last saw her alive on Feb. 19th 1940.

Immediate cause of death: Broncho pneumonia — DURATION: 5 das.

Due to:

Due to:

Other conditions: General paresis

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----

Of autopsy: ----

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ---- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 2/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

01477

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 14 days
Stay in this community (yrs., or mos., or days): ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 703 Y Alley
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: MATTIE JACKSON

3. (b) Social Security Number: Unknown

4. Sex: female
5. Color or race: black
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: George Jackson
6(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 58 Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: -----

FATHER
12. Name: Gilbert Rainwater
13. Birthplace: Georgia

MOTHER
14. Maiden name: Diana Jennings
15. Birthplace: Georgia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Calvert Cemetery
Location: Anne Arundel Co.

18. Funeral director: Isiah L. Brown & Son
Address: 108 W. Montgomery St., Balto.

19. Feb. 19 1940 (Date rec'd by registrar) E. F. Joyce D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19th 1940, at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5th 1940, to Feb. 19th 1940, and that I last saw her alive on Feb. 19th 1940.

Immediate cause of death: Cerebral hemorrhage
Due to:
Due to:
Other conditions: Arteriosclerotic brain disease
(Include pregnancy within 3 months of death)
Major findings:
Of operations: -------
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of:
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownville, Maryland Date signed: 2/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 23 1940
BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

01478

1. PLACE OF DEATH (8)

County A. A. Co. — Registration Dist. No. 23

Village or City Glen Burnie No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Still born infant Johnson If U. S. Veteran, specify WAR

(a) Residence: No. ___ St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M.	W.	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Feb. 3-1940

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Glen Burnie, Md. (State or country)

FATHER

13. NAME John Henry Johnson

14. BIRTHPLACE (city or town) A. A. Co. (State or country) Maryland

MOTHER

15. MAIDEN NAME Anna Johnson

16. BIRTHPLACE (city or town) Washington (State or country) D. C.

17. INFORMANT Father (Address) Glen Burnie, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place ___ Date ___, 19___

19. UNDERTAKER (Address)

20. FILED Feb. 12, 1940 M. S. DeAlba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 3 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___

I last saw h___ alive on ___, 19___; death is said to have occurred on the date stated above, at ___ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Still born infant

Date of onset

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ___

(Signed) J. T. Alexander M. D.

(Address) Glen Burnie, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
MAR 8 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (107)

Reg. Dist. No. 23

01479

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County ANNE ARUNDEL Brooklyn P.O.

(b) City or town Rural - ~~Glen Burnie~~ (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: FURNACE BRANCH ROAD

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 73 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County ANNE ARUNDEL

(c) City or town Brooklyn P.O. ~~Glen Burnie~~ - Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. FURNACE BRANCH ROAD. (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME William Alexander Johnson

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 - 1868

8. AGE: Years 73 Months 11 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Anne Arundel Co. Md (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Farming

FATHER

12. Name Thomas Henry Johnson

13. Birthplace Anne Arundel Co Md

MOTHER

14. Maiden Name Adline -

15. Birthplace Anne Arundel Co Md

16 (a) Informant James A Johnson

(b) Address Furnace Branch A.A.Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7/40 (month) (day) (year)

(c) Cemetery or crematory Furnace Branch Ct

Location Anne Arundel Co Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W. Montgomery St

19 (a) Feb. 7 1940 (Date rec'd by registrar) (b) Mrs De Alba Dep Registrar

MEDICAL CERTIFICATION

20. Date of death February 4 1940, at 6:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1940, to Feb. 4 1940, and that I last saw him alive on 8:30 P.M. Feb. 3, 1940

Immediate cause of death Bronchial Pneumonia — Duration 7 days

Due to

Due to

Other conditions Arteriosclerosis, Senility (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify typo of place) While at work?

(e) Means of injury

23. Signature Earle M. Wilder, M.D. (M. D. or other)

Address Ferndale, Md. Date signed Feb. 4, 1940

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 9 1940
U.S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01480

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs. 10mos. 9 das.

Stay in this community (yrs., or mos., or days): -------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR: ---------

3. (a) FULL NAME: EMALINE JOLLY

3. (b) Social Security Number: Unknown

4. Sex: female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~ xx: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1859

8. AGE: Years: 81 Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER
12. Name: Eisey Washington Jolly
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emaline Mack
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 2/16-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address

19. Feb. 16 1940
(Date rec'd by registrar)

E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14th 1940, at 3 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5th, 1934, to Feb. 14th 1940, and that I last saw him alive on Feb. 14th 1940.

Immediate cause of death: Chronic myocarditis

Due to

Due to

Other conditions: Senile psychosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -------
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ----- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 2/14/40

RECEIVED
MAR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01481

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland House of Correction

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 917 McCulloh Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JOHN JONES

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife: unknown

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-17-79

8. AGE: Years	Months	Days	If less than one day
60	10	25	23 hrs. 40 min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Dan Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Maggie Allen
15. Birthplace: Unknown

16. Informant: Joseph Coates

Address: 7 Monument St. Annapolis, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Feb 17-40 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Jessup Md

18. Funeral director: W L Collins.

Address: Jessup Md

19. Feb 17 1940 (Date rec'd by registrar) Clara M Hasleup. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12th 1940, at 11.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19th 1940, to 2-12-40 1940, and that I last saw him alive on February 12th, 1940.

	DURATION
Immediate cause of death: Acute Myocardial Failure	2-6-40 to 2-12-40
Due to: Chronic Nephritis (Uremia)	unknown
Due to:	
Other conditions: Chronic Bronchiectasis	??

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos. H Phillips M. D. or other

Address: Jessup, Md. Date signed: 2-13-40

RECEIVED
MAR 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7th)

01482

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): life

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 512 Third St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Joseph Huston Jones

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 7th 1937

8. AGE: Years 2 Months 3 Days 29 If less than one day ____ hrs. ____ min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Joseph Miller Jones
13. Birthplace: Rogersville Tenn

MOTHER
14. Maiden name: Ester House
15. Birthplace: Rogersville Tenn

16. Informant: Joseph M. Jones

Address: 512 Third St. Eastport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5th 1940 (month) (day) (year)

Cemetery or crematory:

Location: Rogersville Tenn.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 2-5th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1940, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1940, to Feb 5 1940, and that I last saw h 1 M alive on Feb 5 1940.

Immediate cause of death: Read Pneumonia

Due to: Convulsions

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: ?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Linhardt MD (M. D. or other)

Address: Eastport, Md Date signed: 2-5-40.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-6)

CERTIFICATE OF DEATH

01483

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Emergency Hospital

Stay in hospital or insf. (yrs., or mos., or days) 21 days

Stay in this community (yrs., or mos., or days) 26 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 19 Murry Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry L. Katsef

3. (b) Social Security Number 705-09-1548

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1898

8. AGE: Years	Months	Days	If less than one day
42		27	hrs. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business B&O R. R. Company

FATHER — 12. Name Moses Katsef

FATHER — 13. Birthplace Russia

MOTHER — 14. Maiden name Sarah Feldman

MOTHER — 15. Birthplace Russia

16. Informant Israel Katsef

Address 29 Murry Ave Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 11 1940 (month) (day) (year)

Cemetery or crematory Kneseth Isrrael

Location Three Mile Oak

18. Funeral director B.L. Hopping

Address Annapolis, Md.

19. 2 11 1940 (Date rec'd by registrar) J.M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10 1940, at 6A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937, to Feb 10 1940 and that I last saw h- alive on Feb 10 1940

Immediate cause of death	DURATION
Myocarditis + Myocardial Insufficiency	1937
Due to Hypertension	1937
Due to Chr. Nephritis	1937
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Basil M. D. or other

Address Annapolis Md Date signed 2-10-40

FEB 19 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01484

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Shorelands, Rural Near Glen Burnie

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 12 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Shorelands Rural near Glen Burnie and No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Brooklyn R.F.D.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Louis Klein

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mrs Mary Klein

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 20, 1869.

8. AGE:

Years	Months	Days	If less than one day
71	1		hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Bldg

FATHER

12. Name: Wm. Klein

13. Birthplace: Maryland

MOTHER

14. Maiden name: Caroline Roeder

15. Birthplace: Germany

16. Informant: Mrs. Mary J. Klein

Address: #9 R. F. D. Brooklyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 23 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Annapolis, Md.

18. Funeral director: J. H. McCully

Address: 130 E. Fort Ave.

19. Feb. 22 1940 (Date rec'd by registrar) McPeake Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20, 1940, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Feb 20, 1940, and that I last saw h/m alive on Feb 18, 1940

Immediate cause of death	DURATION
Heart failure	3 days
Due to Arteriosclerosis	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none done

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

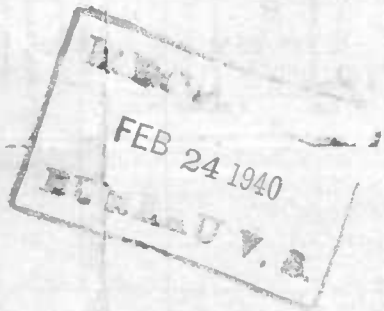
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D. (M. D. or other)

Address: Glen Burnie, Md. Date signed 2-20-40


FEB 24 1940

STATE OF MARYLAND—CERTIFICATE OF DEATH

01485

93-d

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn Pk No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John F. Kohns

(a) Residence: No. 104 4th Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* tha word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Daisy Kohns

6. DATE OF BIRTH (month, day, and year): Aug 31 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Moulder

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Md Brass Works

10. Date deceased last worked at this occupation (month and year): 55 ft 215-12-5017

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Baltimore

FATHER

13. NAME: Henry Kohn

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT (Address): Daisy Kohns 104 4th Ave

18. BURIAL, CREMATION, OR REMOVAL Place Cedar Hill Date 2/10, 1940

19. UNDERTAKER (Address): Phillips Sterling Sons 2016 Eutaw St

20. FILED Feb 10, 1940 John M. Whiteman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 6 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Spring, 1937, to Feb 6, 1940

I last saw h... alive on Jan 23, 1940; death is said to have occurred on the data stated above, at 5 A m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Bronchectasis	before 1927
Myocardial degeneration	1940

Other **Contributory Causes** of importance:

Name of operation — Data of

What test confirmad diagnosis? Clinical — Was there an autopsy?

23. If daath was due to external causes (VIOLENCE) fill in also tha following:

Accidant, suicida, or homicida? Date of injury, 19

Whare did injury occur? (Specify city or town, county and State)

Specify whethar injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Mannar of injury

Nature of injury

24. Was diseasa or injury in any way related to occupation of deceased?

If so, spacify

(Signed) Lawrence H. Sens M. D.

(Address) 104 W Madison St.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes** of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other **contributory causes** of importance:	
Gastroenteritis	*1 year*

FEB 9 1940

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

01486

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-e

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 19 mth. 24 days

Stay in this community (yrs., or mos., or days) ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Ellicot City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR -------

3. (a) FULL NAME Mary Laurence

3. (b) Social Security Number unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	black	widowed

6 (b) Name of husband or wife unknown

---------- 6(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE:

Years	Months	Days	If less than one day
65	--	--	- hrs. min.

9. Birthplace Howard County Md.
(Town, county, and state)

10. Usual occupation domestic

11. Industry or business -----

FATHER
12. Name James Tumey
13. Birthplace Howard County

MOTHER
14. Maiden name Susi Tumey
15. Birthplace Howard County

16. Informant Hospital Records

Address Crownsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27-40 (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville Md.

18. Funeral director Supt.

Address

19. 2/27/ 1940 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2.24. 1940, at 11 50 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30th 1938, to Feb. 24 1940, and that I last saw her alive on Feb. 24 1940.

Immediate cause of death pseudo bulbar paralysis on base of arterio sclerosis cerebri,

Due to

Due to

Other conditions terminal bronchopneumonia
(Include pregnancy within 8 months of death)

Major findings:

Of operations ----

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ---- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE [signature] M. D. or other

Address Crownsville Md. Date signed 2.24.40

VS A15 (I) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

01487

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A A Co
City or town: (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Rural near Mayo
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Edna May Lee

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W	Married

6 (b) Name of husband or wife: Fletcher Lee

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Dec 4 1891

8. AGE: Years	Months	Days	If less than one day
48	2	9	hrs. min.

9. Birthplace: May a a Co. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: Joseph R Dawson

13. Birthplace: a a co

MOTHER 14. Maiden name: Isabella Wier

15. Birthplace: a a co

16. Informant: Mr Marvin Dawson

Address: Mayo md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 11 1940 (month) (day) (year)

Cemetery or crematory: Mayo Cemetery

Location: a a co md

18. Funeral director: Robert F. Smith

Address: 829 west St.

19. Feb 9 1940 (Date rec'd by registrar) Edward Collinson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 9 1940, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 19 to Feb 9 1940, and that I last saw h or alive on Feb 9 1940.

Immediate cause of death	DURATION
Carcinoma liver + stomach + lungs	
Due to	
Due to Carcinoma Breast	1938
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: Ext metastasis

Of operations: Carcinoma abdomen

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Willis Martin M.D.

M. D. or other

Address: Annapolis Md Date signed: 2/9/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

01488

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel.

City or town Nr Brooklyn.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Annapolis Blvd.

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel.

City or town Nr. Brooklyn, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Annapolis Blvd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME George William G Lehr.

3. (b) Social Security Number None.

4. Sex Male

5. Color or race white

6. (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Ida Bothe Lehr.

Ida Bothe Lehr 6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) June 10, 1867

8. AGE: Years 72 Months 8 Days 19 If less than one day ___ hrs. ___ min.

9. Birthplace Balto. County, Md.
(Town, county, and state)

10. Usual occupation Flourist (Rose Grower)

11. Industry or business Flowers.

FATHER
12. Name William M. Lehr
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Muller.
15. Birthplace Germany

16. Informant Mrs William G Lehr.

Address Annapolis Blvd, Brooklyn.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Feb. 21, 1940
(month) (day) (year)

Cemetery or crematory Cedar Hill

Location Annapolis Blvd. A.A.C.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. Feb. 21 1940 (Date rec'd by registrar) McDe alba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1940, at 1150 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1939, to Feb 19 1940, and that I last saw him alive on Feb 17 1940

Immediate cause of death Cerebral Hemorrhage — DURATION Sunstroke

Due to Arterio Sclerosis — 2 years

Due to Chronic Disease of the Heart — 2 years

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? ___ (City or town) ___ (County) ___ (State)

Injured at home, farm, industry, public place (where?) ___

Means of injury ___ Injured at work?

23. SIGNATURE James S. Billingsley M.D.
M. D. or other

Address Glen Burnie Md. Date signed Feb 20, 1940

RECEIVED
MAR 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01489

1. PLACE OF DEATH (94a)

County Anne Arundel Registration Dist. No. 21

Village or City Harwood No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..yrs. ..mos. 45 ds. How long in U.S. If of foreign birth? ..yrs. ..mos. ..ds.

2. FULL NAME William Lindsey If U. S. Veteran, specify WAR

(a) Residence: No. Sylvania, Ohio St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Lindsey

6. DATE OF BIRTH (month, day, and year) Oct. 12, 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	78	4	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. -------

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Columbus Ohio (State or country)

FATHER

13. NAME William Lindsey

14. BIRTHPLACE (city or town) Scotland (State or country)

MOTHER

15. MAIDEN NAME Mary Moler

16. BIRTHPLACE (city or town) Penna. (State or country)

17. INFORMANT Mary Ann Lindsey (Address) Sylvania, Ohio

18. BURIAL, CREMATION, OR REMOVAL Place Toledo, Ohio Date Feb. 19, 1940

19. UNDERTAKER B. L. Hopping (Address) Annapolis, Md.

20. FILED 2-17, 1940 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 16 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1940, to Feb. 16, 1940

I last saw him alive on Feb. 16, 1940; death is said to have occurred on the date stated above, at 2:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary occlusion	sudden
Arteriosclerotic heart disease	3 years

Other Contributory Causes of Importance:

Name of operation none Date of

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19..

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. Riddlemoser M. D.

(Address) Davidsonville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

01490

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 11 days
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Island Creek Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: HEZI LOCKS

3. (b) Social Security Number: Social Security No could not be gotte (Pt. did receive S.Securi

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	black	widowed

6 (b) Name of husband or wife: Unknown
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 80 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General

FATHER
12. Name: John Locks
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Key
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Feb 14 1940 (month) (day) (year)
Cemetery or crematory: Brooks
Location: Calvert Co. Md.
18. Funeral director: Pinkney C. Sewell
Address: Prince Frederick Md.

19. 2/13 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13th 1940, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2nd 1940, to Feb. 13th 1940, and that I last saw him alive on Feb. 13th 1940.

Immediate cause of death: Broncho pneumonia — DURATION: 3 das.
Due to
Due to
Other conditions: Chronic myocarditis General Debility, general arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --------
Of autopsy: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury: ------ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 2/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

01491

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn River near St Helena Island
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 14 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town St. Helena Island Crownsville P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Roscoe L. Massey

3. (b) Social Security Number —

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary E. Massey
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec. 13th 1905

8. AGE: Years 34 | Months 2 | Days 1 | If less than one day ____ hrs. ____ min.

9. Birthplace: Bradford Va (Town, county, and state)
10. Usual occupation: Caretaker of St Helena
11. Industry or business: Island in Severn River
FATHER
12. Name: Howard L. Massey
13. Birthplace: Bradford Va
MOTHER
14. Maiden name: Mary J. Agee
15. Birthplace: Floyd Court Va
16. Informant: Mary E. Massey
Address: Severna Park G.G.C. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 23 1940 (month) (day) (year)
Cemetery or crematory: Fork Cemetery
Location: Fork Harford Co. Md.
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. 2-21st 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 14 1940, at about 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__, and that I last saw h ____ alive on 2/20/40 19__.
Post-mortem Examination

Immediate cause of death: Accidental Drowning
Due to: breaking through ice while crossing river
Due to: on way to St. Helena Island from south shore of Severn River near Herald Harbor
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: none done
Of autopsy: None done

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 2/14/40
Where did injury occur? Severn River (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) in Severn River
Means of injury: drowning Injured at work? While crossing ice
23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. or other
Address: Annapolis Md Date signed 2/20/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

WITHIN CORPORATE LIMITS 01492

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 32 N. Glen Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 32 N. Glen Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME LAURA V. McCORKLE

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife Daniel McCorkle

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1865

8. AGE: Years	Months	Days	If less than one day
74	10	17	hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Oliver E. Holland
Address Annapolis, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Feby. 19, 1940
(month) (day) (year)

Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18. Funeral director John M. Taylor
Address Annapolis, Md.

19. 2-19 1940 J J Murray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1940, at 4 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Feb 17 1940, and that I last saw her alive on January 20 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 3 Months

Due to General Arteriosclerosis — Not Known

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walton H Hoglans M D
M. D. or other
Address Annapolis Md Date signed 2-17-40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01493

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 Days

Stay in this community (yrs., or mos., or days) 2Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Elevaton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Janice E.McIntosh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1939

8. AGE: Years | Months 6 | Days 8 | If less than one day hrs. min.

9. Birthplace Annapoils, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Geo P. McIntosh
13. Birthplace New York

MOTHER
14. Maiden name Caterine M. Bloom
15. Birthplace Ireland

16. Informant Geo P. McIntosh
Address Elevaton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb7 1940 (month) (day) (year)

Cemetery or crematory Holy Cross

Location A.A.County

18. Funeral director B.L. Hopping
Address Annapolis, Md.

19. 26 1940 (Date rec'd by registrar) J.J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4th 1940, at 9.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1940 to Feb. 4 1940 and that I last saw her alive on Feb. 4 1940

Immediate cause of death Bronchopneumonia

Due to Type III Pneumococcus

Due to

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE E. J. Goodbody MD
M. D. or other

Address U. S. N. Acad. Date signed Feb. 6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 8 1940
BUREAU V. S.

01494

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town West Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town West Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arthur C. Miller

3. (b) Social Security Number

4. Sex Male

5. Color or race white

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2nd 1863

8. AGE: Years 76 Months 6 Days 23 If less than one day hrs. min.

9. Birthplace Georgetown D.C.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Washington Miller

13. Birthplace Georgetown DC

MOTHER 14. Maiden name Sophie Tolson

15. Birthplace Woodlawn Md

16. Informant Mrs B. F. Jones

Address Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 25-1940 (month) (day) (year)

Cemetery or crematory

Location Washington, DC

18. Funeral director W. W. Chambers Co.

Address 517 11th St. S.E.

19. 2 25 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1940, at 12.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1939, to Feb 24 1940, and that I last saw him alive on Feb 24, 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	14 hrs
Due to Generalized arteriosclerosis	2
Due to Chr. Nephritis	7
Other conditions Chr. Myocarditis; Senility (Include pregnancy within 3 months of death)	

Major findings:

Of operations none done.

Of autopsy none done.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice F. Klawans, Md M. D. or other

Address 31 Southgate av Date signed 2/25/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01495

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Ferndale No. Broadwater Blvd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Harry Edwards Norris If U. S. Veteran, specify WAR

(a) Residence: No. Broadwater Blvd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Anna Norris

6. DATE OF BIRTH (month, day, and year) June 6, 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Clerk

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Canning & Shipping

10. Date deceased last worked at this occupation (month and year) 1937 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

FATHER

13. NAME Ellmore Norris

14. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

MOTHER

15. MAIDEN NAME Medora Maccabee

16. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

17. INFORMANT Mr. Joseph Norris (Address) Ferndale Md

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Olivet Date Feb 26, 1940

19. UNDERTAKER Margaret G. Tilyard (Address) 1422 Light St

20. FILED Feb 24, 1940 Ida M. Whitson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 23 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1940, to Feb 23, 1940

I last saw h— alive on Feb 23, 1940; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Heart Failure	1 day
Chronic Myocarditis	
with Hypostasis of Heart	3yrs.

Other Contributary Causes of Importance:

Name of operation None Date of

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Harry M. Moore M. D.

(Address) Glen Burnie, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED MAY 11 1928 BUREAU OF V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

01496

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 15 days
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrils P. O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: -----
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: GEORGE PARKER

3. (b) Social Security Number: Unknown

4. Sex: Male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of ~~husband or~~ wife: Lucinda Parker
6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 70 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 25/40 (month) (day) (year)
Cemetery or crematory: Mt. Tabot
Location: Chesterfield, A. A. Co

18. Funeral director: J. B. Johnson
Address: Annapolis

19. 2-25-40 (Date rec'd by registrar) 1940 J. A. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20th 1940, at 10:10 m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. Feb. 5th, 1940 to Feb. 20th 1940 and that I last saw him alive on Feb. 20th 1940.

Immediate cause of death: Chronic myocarditis
Due to
Due to
Other conditions: Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations: -----
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury: ------ Injured at work?

23. SIGNATURE: Herbert P. Phint Goode M. D. or other
Address: Crownsville, Maryland Date signed: 2/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

01497

WITHIN CORPORATE LIMITS OF

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 102 North Linden Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Ellen Peach

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James M. Peach

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14th 1872

8. AGE: Years 67 Months 5 Days 21 If less than one day hrs. min.

9. Birthplace Hyattsville Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Lemuel Clark
13. Birthplace Prince Geo. Co Md

MOTHER
14. Maiden name Kate Hyatt Middleton
15. Birthplace Prince Geo Co Md.

16. Informant J Compton Peach
Address Annapolis Md

17. Burial Date thereof Feby 6th 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All Hallows

Location Davidsonville Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. 2-5th 1940 J J Mmf
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1940, at 6 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1939, to Feb 4 1940, and that I last saw her alive on Feb 3 1940.

Immediate cause of death Cancer of Breast — DURATION about 18 mos.

Due to Cancer

Due to

Other conditions Cancer of Stomach Metastatic — Several months
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Purvis
M. D. or other

Address Annapolis Md Date signed 2/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1910
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01498

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jones
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jones Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Earnestine Ada Pearman

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: Col.
6. (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 20 1939
8. AGE: Years: 6 Months: 8 Days: 4 If less than one day hrs. min.
9. Birthplace: Jones Anne Arundel Co Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: William Pearman
13. Birthplace: Freetown Md.
MOTHER 14. Maiden name: Alma Tucker
15. Birthplace: Browns Woods Md.
16. Informant: William Pearman
Address: Jones Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Broad Neck Feb 7 1940
Location: on Baltimore Rd.
18. Funeral director: Chas. H. Alexander
Address: 43, 45 Northwest St. Annapolis Md.
19. 2-5-40 (Date rec'd by registrar) 1940 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3rd 1940, to Feb 3 1940, and that I last saw her alive on Feb 3rd 1940.

Immediate cause of death — DURATION

Primary Due to: Bronchopneumonia — 3 days
There was no assoc-
Due to: ated disease. C.W.G.R.

Other conditions: [illegible]
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John J. Alexander M. D. or other
Address: [illegible] Date signed: 2/5/40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01499

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Severn Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Donaldson's Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Virginia Phelps.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: James Phelps
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 16 - 1860

8. AGE:

Years	Months	Days	If less than one day
79	7	28	hrs. min.

9. Birthplace: Harmans, Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business

FATHER
12. Name: Samuel Turner
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary A. Watts
15. Birthplace: A. A. Co, Md

16. Informant: Ruth Scola
Address: Severn A.A. Co, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16 - 40 (month) (day) (year)
Cemetery or crematory: Family burying ground
Location: Severn A.A. Co.
18. Funeral director: Wm Cook
Address: 1217 St Paul St

19. Feb. 14 1940 (Date rec'd by registrar) M. R. DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13, 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1939, to Feb. 13, 1940, and that I last saw her alive on Feb. 12, 1940.

Immediate cause of death	DURATION
Senility	1 year
Heart Failure	4 days.
Due to Chronic Myocarditis	6 mos.
Lobar Pneumonia	8 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None done

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Harry Jr. Moore M.D.
M. D. or other
Address: Glen Burnie, Md Date signed: Feb. 13, 1940

FEB 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 01500

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Ward No. 1

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3 Holland

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War

3. (a) FULL NAME Talmage Linwood Prather

3. (b) Social Security Number 214-05-1489

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife None

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26th 1891

8. AGE:

Years	Months	Days	If less than one day
48	5	27	hrs. min.

9. Birthplace Millersville A.A.Co. Md (Town, county, and state)

10. Usual occupation Tinner, Metal worker

11. Industry or business

FATHER

12. Name C. Moreland Prather

13. Birthplace Millersville Md

MOTHER

14. Maiden name Cora Stevens

15. Birthplace Kent Island Md.

16. Informant Cora S. Prather

Address 4 Holland St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25th 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 2-24 1940 (Date rec'd by registrar) J. J. Mayo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1940, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 15 1940 to Feb 22 1940

and that I last saw h im alive on Feb 22 1940

Immediate cause of death	DURATION
Myocardial Insufficiency	1 wk.
Due to Chronic Bronchitis	Unknown
Due to Pleurisy & effusion	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.

M. D. or other

Address Annapolis Md Date signed 2/23/40

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-E)

01501

CERTIFICATE OF DEATH

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Millersville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Indian Landing
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Millersville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Indian Landing
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Frank F. Ramey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife: Mary Ramey
6(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 30, 1876

8. AGE:

Years	Months	Days	If less than one day
63	7	21	____ hrs. ____ min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: attorney-at-law
11. Industry or business

FATHER
12. Name: James M. Ramey
13. Birthplace: Va.

MOTHER
14. Maiden name: Christie Ann Funk
15. Birthplace: Md.

16. Informant: Mary E. Wise Ramey
Address: Millersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23, 1940 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial
Location: Millersville, Md.

18. Funeral director: John J. Mitchell & Sons
Address: 1100 Eutaw Place, Baltimore

19. 2/22/40 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 20 1940, at 11 37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1940, to Feby 20 1940, and that I last saw h(M) alive on Feby 20 1940.

Immediate cause of death	DURATION
Acute cardiac failure	
Due to Embolism	Sudden
Due to Sub-acute endocarditis (aortic and mitral valves)	4 weeks
Other conditions disease)	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE John M. Cleffey M. D. or other
Address Annapolis Md Date signed 2/21/40

RECEIVED
MAR 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

01502

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Station Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G. Meade, Md. Ward No. -
(If outside city or town limits, write RURAL NEAR and give town)

Street No. -
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Epifanio Rivera

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Frances Rivera

6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): November 23, 1893

8. AGE: Years	Months	Days	If less than one day
46	3	6	- hrs. - min.

9. Birthplace: Cayey, Puerto Rico
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Frances Rivera
Address: Ft. George G. Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4th 1940 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

16. Funeral director: Robert Brooks and Son

Address: Baltimore, Maryland

19. February 29 1940 (Date rec'd by registrar)

D. P. CARD, Reg. Col., M.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 29, 1940, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26, 1940, to February 29, 1940, and that I last saw him alive on February 29, 1940.

Immediate cause of death	DURATION
Infarction, coronary.	4 Days
Due to Angina Pectoris	3 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: JOHN J. MADIGAN,
Lt. Col., Medical Corps, M.D. or other

Address: Ft. Geo. G. Meade, Md. Date signed: Feb 29/40

RECEIVED
MAR 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

WITHIN CORPORATE 01503

Reg. Dist. No. 2-1

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U.S. Naval Hospital, Annapolis, Md.

Stay in hospital or inst. (yrs., or mos., or days): Two days.

Stay in this community (yrs., or mos., or days): 35 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 31 East St, Annapolis, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War. SPANISH WAR.

3. (a) FULL NAME: Gaetano (none) Sasso

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Palmina Sasso

6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 6-3-62

8. AGE: Years	Months	Days	If less than one day
77	8	20	____ hrs. ____ min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Musician First Class,

11. Industry or business: Retired, U.S. Navy.

FATHER
12. Name: DECEASED Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: DECEASED Unknown
15. Birthplace: Unknown

16. Informant: R. M. LHAMON, Captain, (MC), USN
Address: U.S. Naval Hospital, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-26-1940. (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery,

Location: Annapolis, Maryland.

18. Funeral director: B. L. Hopping,

Address: 172 West St., Annapolis, Md.

19. 2-24 (Date rec'd by registrar) 1940 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 Feb. 1940 19 40 at 5:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 February 19 40, to 2-23- 19 40, and that I last saw him alive on 2-23- 19 40.

Immediate cause of death	DURATION
PNEUMONIA, LOBAR	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Not performed.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert L. Ware ROBERT L. WARE, Lieut. (MC) USN. M. D. or other

Address: U.S. Naval Hospital, Annapolis, Maryland. Date signed 2-23-40

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46b)

01504

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County A-A-Co.

City or town Churchton Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) no

Stay in this community (yrs., or mos., or days) 45 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A-A-Co.

City or town Churchton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Churchton Rural Dist

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Bernard J Scott

3. (b) Social Security Number

4. Sex 45 M

5. Color or race Col

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha Scott

6(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) April 9 1899

8. AGE: Years 45 40 | Months 10 | Days 2 | If less than one day nos hrs. min.

8. Birthplace Churchton aaco Md.

(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oyster man

FATHER

12. Name George J. Scott

13. Birthplace Churchton Md.

MOTHER

14. Maiden name Lula Garrett

15. Birthplace Baltimore Md.

16. Informant L G Scott

Address Churchton Md

17. Scott Cemt. Date thereof 2-14 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Scott Family Cemt

Location Churchton Md

18. Funeral director E. H. B. Parker

Address 47 Washington Sutton-Md

19. 2-12 1940 W. R. Clayton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1940, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1939, to Feb. 11 1940, and that I last saw him alive on Feb. 1 1940.

Immediate cause of death Carcinoma of stomach (?)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson M. D. or other

Address Lothian Md Date signed Feb. 12, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CORRECTION OF age AUTHORIZED

BY LETTER Filed in Permanent File

UNDER Wilson

INITIALS ab DATE 5/7/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01505

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Tracys Landing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Tracys Landing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME William Thomas Sears

3. (b) Social Security Number 217-14-6335

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Agnes Sears
6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) August 2, 1870

8. AGE: Years 69 | Months 6 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Dunkirk, Calvert Co. Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Thomas Sears
13. Birthplace Md

MOTHER
14. Maiden name Emma Ruth Childs
15. Birthplace Md

16. Informant Owen W. Sears
Address Tracys Landing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 1940 (month) (day) (year)
Cemetery or crematory Friendship Cemetery
Location Nr Friendship Md

18. Funeral director T. A. Hardesty & Son
Address Galesville, Md

19. 2-14 1940 (Date rec'd by registrar) W. P. Clayton Dep Trar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940, to Feb 11 1940, and that I last saw him alive on Feb 11 1940

	DURATION
Immediate cause of death Acute Myocarditis	2 / 1 / 40
Due to Hypostatic Pneumonia	1 / 29 / 40
Due to Bronchial Pneumonia	2 / 7 / 40
Due to	
Other conditions Hypertrophy Prostate	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F B Test M. D. or other
Address Lothian, Md Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

01506

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn P.O. Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: Furnace Branch Road
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Furnace Branch Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Samuel S. Sprinkel

3. (b) Social Security Number: 220-07-7594

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

B (b) Name of husband or wife: Nettie E. Sprinkel

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1879

8. AGE: Years: 60 Months: 2 Days: 1 If less than one day: ____ hrs. ____ min.

9. Birthplace: Harrisonburg, Va.
(Town, county, and state)

10. Usual occupation: Blacksmith.

11. Industry or business: Farm

FATHER
12. Name: Enos S. Sprinkel
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ida C. Frye
15. Birthplace: Virginia

16. Informant: Luther Sprinkel
Address: Westport, Md

17. Burial — Date thereof: Feb 6, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Trinity Cemetery
Location: Dorsey, Md.

18. Funeral director: Frederick A. Cole
Address: 1200 W Lombard St.

19. Feb 5 1940 M. DeAlba Dep. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 3 1940, at 2:12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem Examination, and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to	
Due to	
Other conditions	

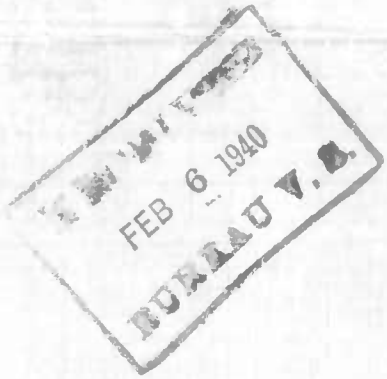
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M Caffey Deputy medical examiner
M. D. or other
Address: Annapolis Md Date signed 2/3/40


FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01507

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Galesville, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Galesville, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None.

3. (a) FULL NAME: Susan Smith Turner

3. (b) Social Security Number

4. Sex: female

5. Color or race: negro

6. (a) ~~Single, married~~, widowed, or ~~divorced~~: widowed

6 (b) Name of husband ~~or wife~~: Edward Smith Turner deceased.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1870

8. AGE: Years: 70 Months: 1 Days: 2 If less than one day ____ hrs. ____ min.

9. Birthplace: Galesville, Md. (Town, county, and state)

10. Usual occupation: Cook.

11. Industry or business

FATHER

12. Name: Edward Turner

13. Birthplace: A. A. County.

MOTHER

14. Maiden name: Charlotte Turner (?)

15. Birthplace: A. A. County.

16. Informant: Jerome Turner

Address: Galesville, Md.

17. (Burial, cremation, or removal) Daniel Star Date thereof: 2/8/1940 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Between West River and Galesville

18. Funeral director: Charles H. Hoffman

Address: 43, 45 Northwest, Annapolis Md.

19. 2/5 1940 (Date rec'd by registrar) J. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1940, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Wed~~ Feb. 1 1940, to Feb 4 1940, and that I last saw her alive on Feb. 2 1940.

Immediate cause of death: Lobar Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Emily H. Wilson M. D. or other

Address: Lothian Md. Date signed: Feb. 4, 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS 01508

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Annapolis Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 58 Spa Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Baby Wallace
3. (b) Social Security Number

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife —
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feby 4th 1940
8. AGE: Years — Months — Days — If less than one day hrs. min.
9. Birthplace A. A. Co Md
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Clinton Wallace
13. Birthplace A. A. Co Md.
MOTHER 14. Maiden name Levinia Taylor
15. Birthplace A. A. Co Md
16. Informant Clinton Wallace
Address 58 Spa Road Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 6th 1940 (month) (day) (year)
Cemetery or crematory Annapolis Yerk
Location Annapolis Yerk, A. A. Co Md
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 2-5-40 (Date rec'd by registrar) 1940 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 4 1940, at 11 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem to examination 19
and that I last saw h alive on 19
Immediate cause of death
Still born infant
Due to Prematurity
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other
Address Annapolis Md Date signed 2/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

01509

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County H. H.

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 32 Holland st

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County H. H.

City or town Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 32 Holland (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henretta Wallace

3. (b) Social Security Number

4. Sex Fem. 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1891

8. AGE: Years 48 Months 3 Days 27 If less than one day hrs. min.

9. Birthplace Davidsonville (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business

FATHER 12. Name Thomas Wallace

13. Birthplace Calvert Co.

MOTHER 14. Maiden name Nancy Green

15. Birthplace Calvert Co.

16. Informant Mary Henderson

Address 32 Holland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 20 1940 (month) (day) (year)

Cemetery or crematory Pottersfield

Location Annapolis

18. Funeral director J. H. Johnson

Address Annapolis

19. 2-20 1940 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1940 19 , at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem, to Examination and that I last saw h alive on 19

Immediate cause of death Acute myocardial failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION sudden

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other

Address Annapolis, Md Date signed 2/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

01510

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Eastport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 607 Severn Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Henry S. Ward

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Florence May Ward

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 20th 1861.

8. AGE:

Years	Months	Days	If less than one day
79	11	3	hrs. min.

9. Birthplace G. A. Co. Md.
(Town, county, and state)

10. Usual occupation Sexton of Church Ret.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Harry S. Ward
Address Gordon Penn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 26th 1940 (month) (day) (year)

Cemetery or crematory Memorial Cemt.

Location Mays 996 Md

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 2-26-1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1940, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22 1940, to Feb 25 1940, and that I last saw him alive on Feb 23 1940

	DURATION
Immediate cause of death Acute Myocarditis & Myocardial Insufficiency	Feb. 22
Due to Arteriosclerosis	unknown
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations	
Of autopsy	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE George C. Beall
M. D. or other

Address Annapolis Md. Date signed 2-23-40

RECEIVED
MAR 15 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01511

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 7-5

Village or City Brooklyn Park No. 213 Fourth Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Mary Wachek

If U. S. Veteran, specify WAR

(a) Residence: No. 213 Fourth Ave St., Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Wachek

6. DATE OF BIRTH (month, day, and year) May 15, 1858

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	9	1.	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last workad at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Bohemia
(State or country)

FATHER

13. NAME Joseph Wachek

14. BIRTHPLACE (city or town)
(State or country) Bohemia

MOTHER

15. MAIDEN NAME Mothers name not known

16. BIRTHPLACE (city or town)
(State or country) Bohemia

17. INFORMANT Mrs. George M. Harrigan
(Address) 213 Fourth Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Holy Cross Date Feb 18, 1940

19. UNDERTAKER Margaret C. T. Lyons
(Address) 1422 Light St.

20. FILED Feb 18, 1940 Hilda M. Whitson
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 16 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1940, to Feb 16, 1940

I last saw her alive on Feb 16, 1940; death is said to have occurred on the data statad above, at 10.0 A.P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Fracture of left thigh	Nov 1939
Senility	
Bronchopneumonia terminal	

Other Contributory Causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury Nov., 1939.

Where did Injury occur? At home
(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of Injury Fell while walking

Nature of Injury Fracture of Fremur

24. Was disease or Injury in any way related to occupation of deceasad? ...

If so, specify ...

(Signed) Lawrence M. Sena M. D.

(Address) 1009 Annapolis Blvd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01512

(94-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 63 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Odenton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3.(a) FULL NAME: Charles Augustus Whittle Sr.

3.(b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Annie M. Whittle

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 2 - 1847

8. AGE: Years 92 Months 7 Days 17 If less than one day ____ hrs. ____ min.

9. Birthplace: Elkridge Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Benj Whittle
13. Birthplace: Howard Co Md

MOTHER
14. Maiden name: Unknown Kinsendorf
15. Birthplace: Howard Co Md

16. Informant: Pete Whittle

Address: Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 2-21-40 (month) (day) (year)

Cemetery or crematory: Nichols Memorial Cem.

Location: Odenton, Maryland

18. Funeral director: Wm. J. Fickner & Sons

Address: North & Pa Avenues

19. Feb 19 1940
(Date rec'd by registrar)

W. L. Jones
D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19 1940, at 12 45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940 to Feb 19 1940 and that I last saw him alive on Feb. 18 1940.

Immediate cause of death: Acute Cardiac Failure

Due to

Due to

Other conditions: Coronary Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: [signature]
M. D. or other

Address: Odenton Md Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 6 1940
BUREAU V. S

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

01513

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Experimental Station, Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Experimental Station Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Annapolis, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clara V. Wiggins

3. (b) Social Security Number None

4. Sex F.

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Daniel G. Wiggins

6(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) April 4, 1907

8. AGE: Years 32 Months 9 Days 27 If less than one day ____ hrs. ____ min.

9. Birthplace Shadyside, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Hallock
13. Birthplace Shadyside

MOTHER
14. Maiden name Sara V. Prouth
15. Birthplace Friendship

16. Informant Daniel G. Wiggins

Address Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 (month) 3 (day) 1940 (year)

Cemetery or crematory Quaker Cemetery

Location Galesville, Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville Md

19. 2 2 (Date rec'd by registrar) 1940 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1940 19 5 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1939, to 2-1 1940, and that I last saw her alive on 2-1 1940.

Immediate cause of death Primary Ca of Rectum Generalized Carcinomatosis

DURATION Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Ca of Rectum Generalized Carcinomatosis

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lenhardt M.D. M. D. or other

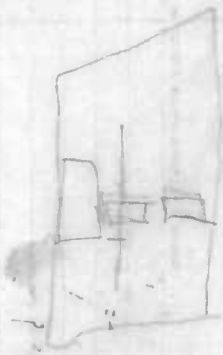
Address Easport Md. Date signed 2-1-40.

Requiem High Mass
at St Mary's Church, Arnold
and at 9.30 A M on Saturday
morning Feb 3, 1940
Interment Locust Cemetery
Glenville Road

Funeral Saturday
Morning at
9.30 A.M. from

Requiem High
Mass at 10 A.M.

RECEIVED
MAR 5 1940
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01514

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Lothian
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Penn Wright

3. (b) Social Security Number None.

4. Sex: M.
5. Color or race: W.
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: Viola Irene Wright
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 18, 1859

8. AGE: Years 80 | Months 6 | Days 13 | If less than one day: hrs. min.

9. Birthplace Phila Pa.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name William Blyth Wright
13. Birthplace Phila Pa

MOTHER
14. Maiden name Mary Ann Heathering ton
15. Birthplace Phila Pa

16. Informant Viola Irene Wright
Address Lothian

17. (Burial, cremation, or removal. Which?) Date thereof 2 4 1940 (month) (day) (year)
Cemetery or crematory Cemetery
Location Wilmington Del.

18. Funeral director H. E. Avery
Address Wilmington Del.

19. 2/1/40 19 W. R. Clayton Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1st 1940, at 1 A M

21. I CERTIFY that death occurred on the date above stated: (that I attended deceased from Jan. 27 1940, to Feb 1st 1940, and that I last saw him alive on Jan. 31 1940.

	DURATION
Immediate cause of death: (a) Acute Myocarditis	7 days
Due to (b) Influenza	Not Given
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F B West M. D. or other
Address Lothian Date signed 2/1/40